



**Employee Notice  
for Unemployment Compensation Coverage  
(Employer's Reciprocal Coverage Election)**

UCS-6B  
R. 12/00



Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Residence Address \_\_\_\_\_

Effective as of \_\_\_\_\_ 20\_\_\_\_, and until further notice, the Florida Unemployment Compensation Law will be the law which applies to all work you perform for the undersigned employer, in any or all of the following jurisdictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This will be true under an election duly filed by the undersigned Employer and approved by the State of Florida Department of Revenue, to which the other jurisdictions listed above duly consented.

If you become unemployed, no matter where you may then be, you should file a claim at the nearest unemployment compensation claims office for benefits under the Florida Law.

SAVE THIS NOTICE, and present it at the unemployment compensation claims office, if and when you file a claim for benefits.

Firm-Name of Employer \_\_\_\_\_

Employer's Florida Account No. \_\_\_\_\_

Date this notice given (or mailed) to Employee \_\_\_\_\_

The employer must complete at least two copies of this notice, and distribute them as follows:

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1. One copy must be delivered (or mailed) to the Employee.
  2. One copy must be sent to the **DEPARTMENT OF REVENUE  
PO BOX 6510  
TALLAHASSEE FL 32314-6510**

I understand and agree  
to the above statements.

\_\_\_\_\_  
(Signature of Employee)

INTERNET ADDRESS: <http://sun6.dms.state.fl.us/dor/>